

Strategic Plan (DRAFT)

**For the
Indian Health Service
Bemidji Area Office Staff**

2001

**Bemidji Area Indian Health Service
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I. Introduction

The Indian Health Service (IHS) is a federal agency within the Department of Health and Human Services. It has primary responsibility to carry out the federal trust responsibility to provide health services to American Indians and Alaska Natives (AI/AN). Administratively, the IHS is divided into 12 Area Offices geographically distributed through-out the United States.

The Bemidji Area of the IHS is responsible for the states of Minnesota, Wisconsin and Michigan. There are 34 tribes and 5 urban Indian health providers within these three states receiving financial or administrative support through the IHS.

The Bemidji Area has been a leader in promoting consultation among the IHS, tribal, and urban (I/T/U) leadership for planning purposes. In 1993, the Bemidji Area consulted with tribes in the development of a strategic plan. Again, in 1997, as the Area Office faced major cutback and reductions, the I/T/U's were asked to participate in a restructuring Work Group for purposes of developing a strategic plan.

Now the Area Office is once again asking tribes to assist in developing a strategic plan. The I/T/U session to develop this plan is scheduled for October 23, 24, 2001 in Green Bay, Wisconsin. In addition to that, the Area will for the first time involve the entire Area Office staff in the development of their own strategic planning. This document represents the work of Bemidji Area staff to define their future operations at the Area Office.

Facts about the Bemidji Area

- Covers 3 states
- Includes 34+ tribes (more coming), 14-15 awaiting recognition and 3 are close
- Includes 5 urban Indian health programs
- Includes 5 alcohol and substance prevention and treatment programs
- Includes 3 IHS Service Units
- There are 7 tribes that are "self-governance" among the 34+ tribes
- 17 tribes have taken (some) tribal shares out of the Area Office
- There are 2 consortiums providing administrative support, the Great Lakes Intertribal Council in Wisconsin and the Michigan Intertribal Council

II. Revisiting the 1997 Strategic Plan

In 1997 the Area Director convened a “Restructuring Work Group” to provide guidance and assistance to the Area regarding the federal cutback and redesign which was occurring at that time. The Work Group was composed of tribal representatives, IHS officials and urban Indian health providers (I/T/U’s). The group was asked to answer the question, “What is the administrative support structure needed to continue and enhance health services in the Bemidji Area in the future?”. To conduct their work, the group engaged in a facilitated strategic planning process, which identified their shared vision for the future, barriers, strategic directions and a more detailed implementation plan.

One of the fundamental first steps undertaken by the Work Group was to identify their “Guiding Principles”. These guiding principles helped shape the tone of their discussions.

- Patient care comes first
- Tribal Sovereignty
- Federal Trust Responsibility
- Be customer centered
- Focus on health
- Cultural sensitivity
- Empowerment and adaptability
- Treat employees fairly
- Excellence
- System-wide simplification
- Full disclosure and consultation
- Respect for diversity of the Bemidji I/T/U system

Based upon these guiding principles, the I/T/U Restructuring Work Group then developed a “shared vision” for the future of the Bemidji Area. Their statement is as follows:

“In partnership and collaboration with tribes and in respect for the diversity of the I/T/U systems in the Bemidji Area, we envision a continued presence of the Bemidji Area Office which will continue contract oversight, budget formulation, advocacy for increased funding on behalf of I/T/U’s and other inherent federal functions or legislative mandates; and will develop effective ways of doing business to meet the needs of I/T/U’s based upon and as determined by tribal share investments, to include the following:

- ***Coordinate public health functions with I/T/U’s;***
- ***Assist I/T/U’s with human resource recruitment, retention, and development;***

- *Communicate with I/T/U's using compatible systems and a rational, state-of-the-art, interactive MIS;*
- *Be an advocate in assisting and supporting the collaboration of I/T/U's in dealing with Federal and State issues, so that Indian tribes and communities will have access to all federal health dollars available to them and to serve as a clearinghouse for technical assistance to meet the changing needs of the I/T/U's."*

To achieve this vision for the future, and in consideration of the numerous obstacles and barriers which stood in the way, the Work Group identified four major strategic directions which would set the course for future planning. Those four major strategic directions included:

- Design a new competitive business oriented paradigm for I/T/U's
- Uphold tribal sovereignty and federal trust responsibility;
- Develop a system for on-site technical assistance that makes effective use of limited resources;
- Establish a process for ongoing assessment, planning, implementation, and evaluation with I/T/U's

These four major areas provide the framework around which implementation planning was developed. The Work Group identified numerous measurable activities and objectives which could be achieved in each of the four areas. Their Implementation Plan and the progress that was achieved in each area is described below.

1997 Implementation Plan Update

Design a new competitive, business oriented paradigm for I/T/U's	Progress to date
<p>Beginning October 1, 1997</p> <ul style="list-style-type: none"> • Establish a workgroup for I/T/U reps to develop needs assessment on business capabilities and personnel • Establish MIS workgroup <p>Beginning January 1, 1998</p> <ul style="list-style-type: none"> • Implement the business and MIS capability assessment locally • Seek input from I/T/U's regarding policy changes <p>Beginning April 1 1998</p> <ul style="list-style-type: none"> • Develop and prioritize plan to enhance business capabilities of all I/T/U's <p>Beginning July 1, 1998</p> <ul style="list-style-type: none"> • Evaluate and reassess as needed 	<ul style="list-style-type: none"> ✓ 1999 MIS workgroup sanctioned by Tribal Advisory Board ✓ 1999 Needs Assessment Done ✓ Barriers Experienced <ul style="list-style-type: none"> - Hardware/wiring not there - Tribal buy-off on plans (ongoing process) - Local turn-over ✓ Area put in writing what services they will provide re. MIS ✓ Area has continued to deliver service even when tribe takes shares
Uphold tribal sovereignty and federal trust responsibility	Progress to date
<p>Beginning October 1, 1997</p> <ul style="list-style-type: none"> • Tribal leads education campaign targeting local, state, federal officials; • Area Director and tribal leaders meet with state health and legislative officials; • Area Director updates tribal leaders at least quarterly; • IHS HQ summarize legislative, policy issues <p>Beginning January 1, 1998</p> <ul style="list-style-type: none"> • Hold meetings with state and legislative officials; • Quarterly briefings by AD continues; <p>Beginning April, 1998</p> <ul style="list-style-type: none"> • Meetings with federal officials from Region V held. 	<ul style="list-style-type: none"> ✓ BAO co-sponsored meeting with State of MN (all levels) about Tribal Sovereignty and Federal Responsibility ✓ Tribes actively working with states (Wisconsin, Michigan, Minnesota leaders meet regularly) ✓ A.D. and tribal representatives gave in-service to Region V ✓ Work with State to I.D. state liaison position, mostly with Medicaid ✓ Tribes in 3 states hold legis. Dinners each year ✓ Minnesota Indian Chairman's Association and Minnesota Indian Affairs Council advise state
Develop a system for on-site technical assistance	Progress to date
<p>Beginning October 1, 1997</p> <ul style="list-style-type: none"> • Develop needs assessment of TA needs and resources; • IHS/BAO works with I/T/U system to define priorities for TA, parameters of public health issues, and reach consensus 	<ul style="list-style-type: none"> ✓ Each department ✓ ½ K training ✓ Problems <ul style="list-style-type: none"> - Those tribes that take shares and still need TA - Tried to work with tribes leaving shares to meet their needs, to prioritize their needs ✓ 1997 Formed self-determination team meeting

<p>on Area residual functions Beginning January 1, 1998</p> <ul style="list-style-type: none"> • Identify training needs, prioritize, and schedule • I/T/U's and Area advocacy with states on state health plans and increased billing revenues <p>Beginning April 1, 1998</p> <ul style="list-style-type: none"> • I/T/U's and Area identify people by function at Area level • Continue needs assessments on TA <p>Beginning July 1, 1998</p> <ul style="list-style-type: none"> • Provide training on history of Indian health, budget process, sovereignty • Train state officials on same issues 	<p>monthly re. I/T/U issues and response – more of a “team focus”</p> <ul style="list-style-type: none"> ✓ Prototype Area Master Plan “Business Plan”
Establish ongoing assessments, planning, implementation and evaluation	Progress to date
<p>Beginning July 1, 1997</p> <ul style="list-style-type: none"> • Share Redesign Plan with tribal leaders • AD meets with individual tribes • Restructure Work Group continues • Redefine BAO mission with tribes • Distribution plans for 100% shares <p>Beginning October 1, 1997</p> <ul style="list-style-type: none"> • Planning, consultation with consortia • Quarterly meetings of Workgroup • Final Plan adopted by tribes <p>Beginning April 1, 1998</p> <ul style="list-style-type: none"> • AD and Work Group review the Strategic Plan for amendments 	<ul style="list-style-type: none"> ✓ All tribes received plan ✓ Shares letter from Area ✓ Planning and consultations <ul style="list-style-type: none"> - - 2 all I/T/U per year - - Quarterly Tribal Advisory Board - - Annual budget formed - - Annual pre-negotiation meeting - - And other groups: Great Lake Intertribe, MN Alliance of Sovereign Tribes ✓ Review of plan 1997, 98, 99 with every tribe – ✓ AD meets with each tribe at least once in 3 years

II. Understanding the Environment

There have been significant changes in the field of Indian health nationally. For the Bemidji Area Office, these changes have had dramatic impacts on the size, function and organization of the office. The Area Office has been impacted by changes at the headquarters level of IHS, as the national office downsizes and functions are forwarded to the Area level. The Area Office has been impacted by the reductions in funding resulting from removals of tribal shares from the Area budget.

Facts about the work that is performed by the Area Office

- Networking with a wide variety of folks
- Manage the 3 IHS Service Units
- Resource allocation
- Advise and educate
- Technical Assistance (TA) and Computer assistance
- Budget formulation in consultation with I/T/U's
- Consultation with tribes on a variety of topics
- Research and evaluation support
- Negotiation of contracts and compacts
- Computer training
- Hiring and personnel process for all federal employees
- Help tribes obtain outside resources
- Manage Human Resources for 457 total IHS employees
- Dissemination point for information
- Respond to all inquiries
- Respond to members of Congress
- Manage construction projects
- Program reviews conducted
- Award contracts
- Recruiting and retention point for professional employees (Federal and Tribal)

Changes observed by staff in the last 4 years

- Tribes deciding on construction issues rather than the IHS
- Contracting went from structured and clear to flexible and "gray"
- CHS eligibility issue is now starting to change at tribal level
- Tribes more involved in budget formulation
- IHS has gone from leading the way to following or collaborating
- Questions harder to answer, need legal help more often
- Service delivery priorities need to "step out of box" to reassess effectiveness
- Confusion among Area staff about which services are to be provided to which tribes, given removal of shares by ½ the tribes.

- Tribes not required to report data, but Area is required to report data, very difficult.
- Confusion about who does which task due to downsizing at Area Office
- Structure of the office has changed
- More requests for Area staff to participate on national Workgroups for HQ
- More cross training than before
- Time keeping and leave has changed
- Increased environmental laws and requirements for construction
- Role of HQ changed drastically (reduced services), and shifting to Areas
- Financial management system changed to an unreliable system
- Increased external demands on staff
- Now have department budget inside Area, i.e. travel
- Increased workload with focus on travel and meeting coordination
- Becoming “multi-tasked” and overwhelmed
- GPRA requirements complicates services and reporting
- Becoming generalists
- From directive management style to consultation style
- More travel for some, less for others
- Purchasing is easier with cards issued
- More use of technology with email, and ARMS
- Tribes designing own programs
- Role of IHS changed to “empowering” tribes, and IHS more involved in conflict negotiations and increased consultation and helping to build infrastructure.
- Greater diversity and disparity among the tribes served based upon the aggressiveness of each tribe
- Tribes funding bigger percentage of their programs from non-IHS sources
- Hard to keep pace with technology changes

IV. VISION

The Bemidji Area staff were asked to engage in discussion about the future of their office. Specifically, the Area staff were asked to answer this question:

“What do we want to see in place at the Area Office in four years?”

Through a highly participatory process, the Area staff reached consensus on a vision for the future which contains four major components. Those are described below:

In the next four years, the Bemidji Area staff envisions an office that will include four major components:

Respect and Accommodation for quality and competent staff....

- *Competent and quality Human Resource management system;*
- *Employee friendly facilities*

Effective Communications....

- *Improved communication and orientation within the Area Office;*
- *Clear communication internally and externally regarding the roles and responsibilities for specific programs, functions, services and activities.*

Effective and accessible support systems....

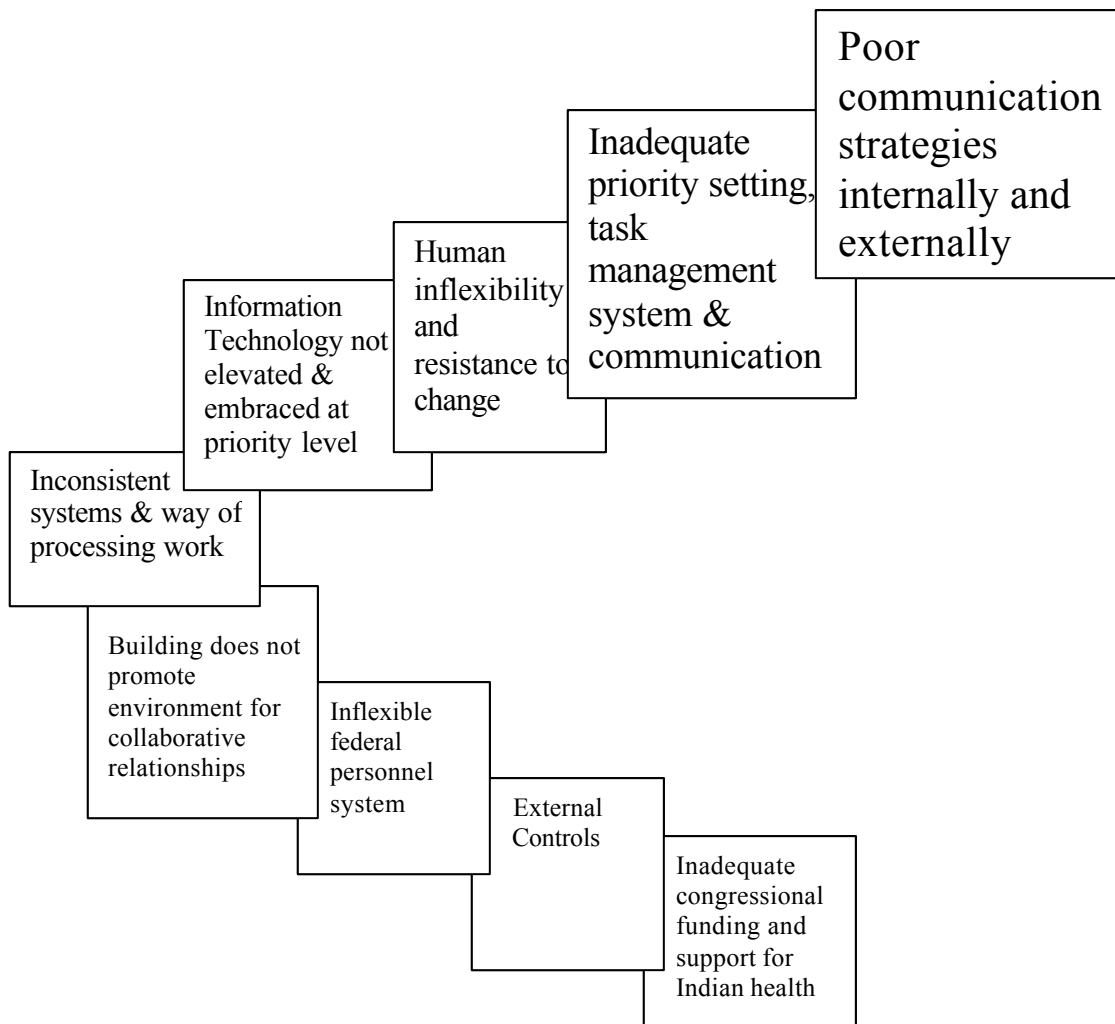
- *Technology systems coordination and training;*
- *Access and training for online budget and integrated financial management systems;*
- *More efficient and effective internal management systems*
- *Better, clearer systems and relationship with the Aberdeen Area Office*

National involvement and leadership

- *Advocacy and leadership on national health issues and funding*

V. Challenges and Barriers

To achieve the stated vision for the future BAO office, it is necessary to recognize the challenges and barriers which prevent or impede progress. The Area Office staff worked together to identify nine (9) specific barriers. These are described below in order of the most immediate barrier to the last barrier. By sorting the barriers in this fashion, we can see what strategies and activities need to occur first, second and so on. The first obstacle which must be addressed is “Poor communication strategies internally and externally”.



VI. Strategic Directions

(THIS SECTION WILL BE COMPLETED AT OUR SECOND RETREAT)

VII. 2001 Implementation Plan

(THIS SECTION WILL BE COMPLETED AT OUR SECOND RETREAT)

ATTACHMENTS

VISION WORK SHEET

CHALLENGES AND BARRIERS WORK SHEET

Competent and Quality H.R. System		Employee Friendly Facilities	Improved communication and orientation	Clarify & communicate specific PFSA roles & responsibilities intern. & extern.	Technology systems coordination and training	Access & training for online budget & integrated financial mgmt. system	More efficient and effective internal system	Advocacy & leadership on national health issues and funding	Better systems relationship with Aberdeen
Successor Planning	That we are employed	Employee lounge	Improve communication within area. Staff to staff to management	Role defining	Standardize RPMS with tribes	Integrate financial information (share)	Standardize processes	CHS dependent programs have adequate resources	Become a real Area Office
Streamline Personnel	Increase NA's in our health profession	Parking	The need for all depts. to understand what each other dept. does (duties & responsibilities)	Define/focus on services we can actually provide well (quality not quantity)	RPMS – current tech. meets needs of I/T/U's	Integrated finance system	Better records management	Website access of legal opinion	Self-sufficient service units
Speed up hiring process	Flexible positions generalists vs. specialists	Better office temperature control	Integrated current administrative systems	Responsibilities with shares	RPMS coordination (training/TA)	Real-time budget	Task Order system	IHS prevention model is national model	Less dependent on Aberdeen
Career development	Utilizing of <u>Manpower</u> more efficiently!	Exercise equipment room	Communicate better	Centralized negotiation duties	More video-conferencing	Dept. budgets – Depts. Properly trained	Increase purchase authority with increased accountability	IHCIA reauthorization	
Staff career development	Institutional knowledge record/plan	Location of area in Bemidji or out (resolved)		All new tribes in the system and being served	Standardize area computers (all at once)				
Orientation	Making hiring process comparable to private sector	Adequate parking		BAO downsized/ redesigned	State of the art office equipment				
Retirement Buy-out				Public health nurse expertise – new tribes	State of the art computer systems with training				
				Clearer/ specific role definition	I.T.U. “standardized” systems				

OBSTACLES

Poor communication strategies int/ext	Inadequate priority setting task mgmt. system & communication	Human inflexibility & resistance	I.T. not elevated & embraced to priority level	Inconsistent systems & ways of processing work	Building does not promote collaborative environment (relationships)	Inflexible fed personnel system	External controls	Inadequate congressional funding & support for Indian health
Delayed communication	Fragmentation -vision -policy -priorities -unfocused	Complacency -comfort level established, stay the course	No training to keep up with fast changing technology	Standardized systems not in place	City parking policy	Manpower shortage	Excessive bureaucracy	Inadequate resources for new tribes staffing expertise
Poor communication - - Misconceptions - - Resistance to change - - Encrusted in tradition	Conflicting priorities	Individual attitude/style	Insufficient info. on technology info.	Systems complexity	GSA – own agenda	Unfilled positions	Difficult to change base systems – other factors interfere	Inadequate training/ orientation for new health directors
Team work no coordination	Reactive vs. proactive	Fear of change	RPMS is not accepted as the best	Aberdeen uncooperative – has their own policies & procedures	GSA realty	Flexible personnel system	Outdated regulations	Too easy to leave some tribes behind
Knowledge of others duties/ positions	Multiple demands at once	Staff committed to traditional roles	I.T. is not treated as a major business decision			Salaries not competitive with private sector for many positions	Regulations -affect multiple goals -self explanatory	Trying to fit national budget into local needs
Supervisors & colleagues not keeping staff informed	Work load distribution too much	Too many cooks	Changing environment technology				Out dated personnel regs.	IHS not an entitlement
Skepticism of our intentions	Unplanned deadlines							
Awareness of dept. functions	Time (not enough)							
We don't market ourselves well	Disorganized approach							
Consistency of message between								

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